King County Deputy Sheriff Dental Plan

Finalized April 9, 1999
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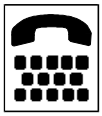
Directory

If you have questions about ...	Contact …
• Eligibility • Completing the enrollment form • King County Deputy Sheriff benefit program	Employee Benefits and Well-Being at (206) 684-1556 Monday - Wednesday between 8:30 a.m. and 4:30 p.m. Thursday between 10:30 a.m. and 4:30 p.m. Friday between 8:30 a.m. and 4:30 p.m. King County employee intranet (through the King County computer system) at http://ohrm/metrokc.gov/benefits
• Details about plan benefits (such as covered expenses, limitations, exclusions) • Participating dentists • Incentive program	Washington Dental Service, (206) 522-2300 or (800) 554-1907 Monday - Thursday between 8:00 a.m. and 6:00 p.m. or Friday between 8:00 a.m. and 5:00 p.m.
• General information about Washington Dental Service (King County-specific information on benefits is not available on the WDS web site) • Participating provider list for all participants (including King County employees)	Washington Dental Service web site at www.ddpwa.com

The information in this booklet is available in accessible formats by calling Employee Benefits at (206) 684-1556 (voice) or (206) 296-8535 (TDD), or through Washington State Telecommunication Relay Service at (800) 833-6388 (TDD).



HOW TO USE THIS BOOKLET

This booklet describes the dental coverage available to you and your family members if you are an eligible King County Deputy Sheriff employee. It summarizes the benefits, describes when coverage begins and explains how to use this plan. See your enrollment materials for details on enrollment procedures and deadlines, coverage options and related cost information.

Shaded areas throughout the booklet highlight key points for your convenience.

This booklet uses a number of technical terms you will need to know to understand your benefits. For your reference, we've defined many terms in "Definitions" starting on page 24.

Keep this booklet and refer to it whenever you have a question about your dental coverage. If you still have questions, contact the plan as shown in the Directory in the front of this booklet. You may also call Employee Benefits and Well-Being at (206) 684-1556.

Although this booklet includes certain key features and brief summaries of your dental coverage, it does not provide detailed descriptions. If you have questions about specific plan details, contact the plan or Employee Benefits and Well-Being.

We've made every attempt to ensure the accuracy of this information. However, if there is any discrepancy between this booklet and the insurance contracts or other legal documents, the legal documents will always govern.

King County intends to continue this plan indefinitely but reserves the right to amend or terminate it at any time, for any reason, according to the amendment procedures described in the legal documents.

This booklet does not create a contract of employment with King County.

LEARN MORE ABOUT … ON PAGE …

Visit the King County employee intranet (accessible only through the King County computer system) at http://ohrm/metrokc.gov/benefits.

Visit the Washington Dental Service web site at www.ddpwa.com

LEARN MORE ABOUT (cont'd)… ON PAGE …

HIGHLIGHTS

This plan covers diagnostic and preventive care (such as exams, cleanings and x-rays), basic and major services (such as fillings, crowns and dentures) as well as orthodontic services for you and your family members.

Here are a few highlights:

- You can use any dentist you wish; the plan pays benefits whether you see a participating or non-participating dentist
- Participating dentists will file claims for you automatically
- If you use a non-participating dentist, you are responsible for charges that exceed usual, customary and reasonable (UCR) rates (see page 26 for the definition of UCR).

Claim processing is provided by Washington Dental Service (WDS), an organization that contracts with thousands of dentists throughout the state.

WHO'S ELIGIBLE

Employees

You are eligible for dental coverage if you are:

- A represented, commissioned employee in a regular, active, year-round position and scheduled to work at least 35 hours each week, or
- A represented, commissioned employee in a regular, active, year-round position and scheduled to work under 35 hours each week — if your position has at least 10 pay periods of uninterrupted service a year with 5 full-time work days or the equivalent of 35 hours a pay period

Retirees

Retirees are not eligible for the dental coverage described in this booklet.

Family Members

A child is your natural child, adopted child, stepchild, legally placed foster child, legally designated ward, child placed with you as legal guardian, child legally placed with you for adoption, or a child for whom you assume total or partial legal obligation for support in anticipation of adoption.

The following family members are eligible for dental coverage:

- Your spouse or domestic partner named on the Affidavit of Marriage/Domestic Partnership on file with Employee Benefits and Well-Being.
- Unmarried children of you, your spouse or declared domestic partner who are:
  - Under age 23 and chiefly dependent on you for support and maintenance (generally that means family members you claim on your federal income tax returns).
  - Incapacitated due to developmental or physical disability and chiefly dependent on you for support and maintenance. The child must have become incapacitated while covered by the plan and before age 23. You must submit proof of the child's disability for enrollment (and periodically thereafter).

To continue an incapacitated child's coverage after age 23, contact Employee Benefits and Well-Being within 60 days of the child's 23rd birthday.

  - Named in a Qualified Medical Child Support Order (QMCSO) as defined under federal law and authorized by the plan. See page 16 for details.

COST

The county pays the full monthly cost of coverage for you and your eligible family members under this plan.

When you receive dental care, you pay:

- Coinsurance, if any
- Amounts in excess of UCR rates unless you see a participating dentist
- Expenses for services or supplies not covered by this plan.

ENROLLING IN THE PLAN

Your eligibility date is the first day of the calendar month after 6 months of continuous service.

If you are a newly hired employee, you must submit a completed enrollment form to Employee Benefits and Well-Being within 30 days of your hire date. See your enrollment materials for details.

Making Changes

To add coverage during the plan year, notify Employee Benefits and Well-Being and submit a completed enrollment form within 60 days of the family status change. Otherwise, you must wait until the next open enrollment period.

Each year during open enrollment, you may change your elections.

You may drop family members' coverage anytime during the year. You may add family members' coverage during the plan year if any of these changes in family status occurs:

- Birth or placement of a child with you for adoption
- Placement of a foster child
- Loss of your child's eligibility under another health plan
- Death of a family member
- Marriage or establishment of a domestic partnership
- Divorce or dissolution of a domestic partnership
- Significant change in your spouse's or domestic partner's coverage attributable to his or her employment.

Enrollment forms are available from and must be submitted to Employee Benefits and Well-Being. You'll need to file a revised enrollment form within 60 days if there is any change in your family's eligibility.

Any change you make must be consistent with the change in family status. Here are several examples:

- If you adopt a child, you may add coverage for that child (you may not add coverage for your other children at that time)
- If your child loses coverage under your spouse's coverage, you may add this child to the county's plan
- If you get married, you may enroll your new spouse and his or her eligible children.

WHEN COVERAGE BEGINS

If you enroll during the year as a newly hired employee, your dental coverage begins on the first day of the calendar month after you complete 6 months of work. If your first day of employment is the first working day of the month for your position, that month applies to the waiting period. For example, if your first scheduled day of work is Saturday April 3 (because Thursday and Friday will be your regular days off), your coverage begins October 1. If your first day of employment is April 15, your coverage begins November 1.

Coverage for your family members does not start until your coverage begins and you submit a completed enrollment form listing the family members you want to cover. If your dependents are not enrolled in this plan and have other coverage — and lose that other coverage — they may be able to enroll in this plan during the year. Contact Employee Benefits and Well-Being at (206) 684-1556 for more information.

If enrolled by the deadline (described in "Making Changes" on page 3), coverage for your:

- Newborn or newly placed adopted child is retroactive to the date of birth or placement
- New spouse begins the first day of the calendar month after you're married
- Domestic partner begins the first day of the calendar month after the date you establish a domestic partnership as indicated on the Affidavit of Marriage/Domestic Partnership.

HOW THE DENTAL PLAN WORKS

Dental Plan Summary

The following table summarizes covered dental services and supplies and identifies related coinsurance and maximums. Please refer to "Covered Expenses" and "Expenses Not Covered" for more information on your dental benefits and related limitations.

Dental Plan		For More Information Refer To ...
Annual deductible	None	—
Annual maximum benefit (doesn't apply to orthodontic and orthognathic services)	$2,500/person	Page 6
Covered Expenses	**Plan Pays**	
Diagnostic and preventive services – 1 exam every 6 months – Complete x-rays every 3 years – Supplementary bitewing x-rays every 6 months – 1 cleaning every 6 months	70% – 100%	Page 8
Basic services – Fillings – Crowns (stainless steel) – Extractions – Root canals – Periodontics	70% – 100%	Page 8
Major services - restorative – Crowns – Onlays – Fixed bridges	70% – 100%	Page 9
Major services - prosthodontics – Dentures	70%	Page 10
Orthodontic services (for adults and children)	60%, up to a $2,500 lifetime maximum benefit❷	Page 10
Orthognathic surgery	70%, up to a $5,000 lifetime maximum benefit	Page 11
Accidental injury	100%	Page 11

Based on your incentive level; see page 6.

❷ Not more than $1,250 will be paid during the initial stage of treatment. The remaining plan benefit is paid 7 months after the initial stage, if you still meet eligibility requirements outlined on page 1.

Participating and Non-participating Dentists

You may select any licensed dentist. Tell your dentist you are covered by a WDS dental program and give your dentist your Social Security number, the program name and the group identification number (which is 152).

If you go to a participating dentist, the dentist will submit claim forms to WDS and receive payment directly. You are responsible for any remaining balance.

For a list of participating dentists, call WDS at (206) 522-2300 or (800) 554-1907.

If you see a non-participating dentist, it's your responsibility to see that the claim form is submitted. See "Filing a Claim" on page 15 for details.

Benefit Maximums

The maximum the plan pays each year for all covered expenses (excluding orthodontic and orthognathic care) is $2,500/person. The lifetime maximum payable by WDS for orthodontic treatment is $2,500/person. The lifetime maximum payable by WDS for orthognathic surgery is $5,000/person.

Charges for dental procedures requiring multiple treatment dates (such as crowns or bridgework) will be considered received on the date the service is complete (at that time the amounts paid for the procedures will be applied to your annual maximum).

Incentive Plan

Incentive levels do not apply to orthodontic or prosthodontic care or orthognathic surgery.

Incentive benefits are designed to encourage you to seek regular dental care. Here's how they work: The plan pays 70% of covered costs the first year you participate. After that, the coverage level for most covered services will increase 10% each consecutive calendar year you receive covered dental care. You must visit the dentist at least once a year to increase or maintain your payment level.

Each year you don't visit the dentist, the coverage level decreases 10% — but your payment level will never be less than 70%.

The following table summarizes how the incentive plan works for each participant.

If you receive these services ...	The plan pays ...
Diagnostic and preventive services, basic services, major services — restorative	70% first calendar year 80% second calendar year 90% third calendar year 100% fourth calendar year and each year thereafter

Predetermination of Benefits

An estimate of benefits is required for all orthodontic and orthognathic treatment.

If you expect your dental care to be extensive — and for all orthodontic and orthognathic work — ask your dentist to submit a standard WDS claim form for an estimate. This way you'll learn in advance exactly what procedures are covered, the amount WDS will pay toward the treatment and the amount you'll need to pay.

Example 1

This is Rachel's second year of plan participation. This year, Rachel visits her participating dentist for her annual cleaning. Since she visited the dentist last year, her coinsurance level for this year increased from 70% to 80%.

Here's how much Rachel pays:

Total Expense	Plan Pays	Rachel Pays
$45 (exam)	$36 (80% of $45)	$9 (20% of $45)

Example 2

Jim has participated in this plan for 3 years, but hasn't been to the dentist during any of those years. This year Jim needs a root canal.

Here's how much Jim pays:

Total Expense	Plan Pays	Jim Pays
$45 (exam)	$40.50 (90% of $45)	$4.50 (10% of $45)

COVERED EXPENSES

Covered benefits under this program are subject to the limitations and exclusions contained in this booklet. Benefits are payable only when provided by a licensed dentist or other WDS-approved licensed professional when appropriate and necessary (as determined by the standards of generally accepted dental practice and WDS).

This section describes covered expenses and any related limitations. For information on the level of benefits you receive (for example, coinsurance and maximums), see "Dental Plan Summary" on page 5 and "Incentive Plan" on page 6. Also see "Expenses Not Covered" starting on page 11.

Diagnostic and Preventive Services

- Exam — emergency
- Exam — routine, once in 6 months
- Exam by a specialist (see definition on page 26)
- Fissure sealants for permanent molars, for children age 13 or younger, once in 3 years per tooth
- Prophylaxis (cleaning), once in 6 months
- Space maintainers for the eruption of permanent teeth
- Topical application of fluoride once in 6 months for children age 18 or younger when performed with a cleaning
- X-rays — complete series or panorex x-rays, once in 3 years; supplementary bitewing x-rays, once in 6 months.

Basic Services

- Amalgam, filled resin or composite fillings to treat decay or fracture resulting in significant tooth loss (resin or composite fillings placed in a posterior tooth will be covered at the amalgam allowance)
- General anesthesia/intravenous sedation, if administered by a licensed dentist or other WDS-approved licensed professional who meets the state Dental Quality Assurance Commission guidelines in conjunction with certain covered surgical procedures as determined by WDS

- Preparation of the alveolar ridge and soft tissue of the mouth for insertion of dentures
- Pulp exposure treatment, pulpotomy and apicoectomy
- Pulpal and root canal treatment (root canal treatment on the same tooth is covered once in 2 years)
- Removal of teeth and surgical extractions
- Restorations on the same surface(s) of the same tooth, once in 2 years (if a filled resin or composite filling is placed in a posterior tooth, the plan pays benefits as if it were an amalgam)
- Stainless steel crowns, once in 2 years
- Surgical and nonsurgical procedures to treat the supporting tissues, including periodontal scaling/root planing (once in 12 months), limited (8 teeth or fewer) occlusal adjustments (once in 12 months) and gingivectomy
- Treatment of pathological conditions and traumatic facial injuries.

If teeth are restored with crowns, inlays or onlays, refer to the following sections.

Major Services ¾ Restorative

- Crowns (on the same teeth, once in 5 years)
- Fixed bridges, inlays if used as an abutment for a fixed bridge (on the same teeth, once in 5 years)
- Onlays (on the same teeth, once in 5 years).

Gold, porcelain, WDS-approved gold substitute castings (except processed resin) or combinations of these may be used in major restorative services.

Crowns and onlays are covered only to treat decay or fracture resulting in significant tooth loss (missing cusp), when teeth cannot reasonably be restored with filling materials such as amalgam or resin.

If professional dental standards indicate a condition can be treated by a less costly alternative to the service proposed by your dentist, this plan will limit benefits to the cost of the alternative treatment. You are responsible for any costs exceeding UCR fees for the alternative treatment.

Major Services ¾ Prosthodontics

- Dentures, removable partial dentures and adjustment or repair of an existing prosthesis — unless limited by:
    - Denture adjustments and relines done more than 6 months after the initial placement. These are covered, except as noted under temporary/interim dentures below. Subsequent relines or rebases, but not both, will be covered once in 12 months.
    - Dentures (temporary/interim). If you receive an interim partial or full denture, the plan pays as if you received a reline. After placement of the permanent prosthesis, an initial reline is covered after 12 months.
    - Dentures (partial). If a more elaborate or precision device is used, the plan pays as if you received a cast chrome and acrylic partial denture.
    - Full, immediate and overdentures. For personalized restorations or specialized treatment, the plan pays as if you received a full, immediate or overdenture.
    - Implants. For appliances constructed on implants, the plan pays as if you received a standard crown, bridge, partial denture or full denture. The plan doesn't pay for any replacement within 5 years of initial placement.
    - Replacement of an existing prosthetic device. This is covered once in 5 years and only then if it's unserviceable and cannot be made serviceable.
    - Root canal treatment performed in conjunction with overdentures. This is limited to 2 teeth/arch.

Orthodontic Services

This plan covers orthodontic care for adults and children. All orthodontic treatment must be authorized by WDS before treatment begins. See "Predetermination of Benefits" on page 7 for details.

Orthognathic Surgery

The plan covers orthognathic treatment to correct malpositions of the upper jaw bone (maxilla) and/or the lower jaw bone (mandible). All orthognathic treatment must be authorized by WDS before treatment begins. See "Predetermination of Benefits" on page 7 for details.

Accidental Injury

This plan pays 100% of dental expenses directly resulting from an accidental bodily injury (see definition on page 24), up to the annual maximum, within 180 days after the accident. The accidental bodily injury must have occurred while the patient was eligible. A bodily injury does not include teeth broken or damaged while chewing or biting on foreign objects.

EXPENSES NOT COVERED

In addition to the limitations and exclusions described in this booklet, the Dental Plan does not cover:

Diagnostic and Preventive Services

- Consultations or elective second opinions
- Decay susceptibility tests
- Diagnostic services and x-rays related to temporomandibular (jaw) joints
- Plaque control program (oral hygiene instruction, dietary instruction or home fluoride kits)
- Replacement of a space maintainer previously paid for by WDS
- Study models.

Basic Services

- Bleaching of teeth
- Crowns as part of periodontal therapy

Basic Services (cont'd)

- Gingival curettage
- Iliac crest or rib grafts to alveolar ridges
- Major (complete) occlusal adjustment
- Nightguards or occlusal splints
- Overhang removal, recontouring or polishing of restoration
- Periodontal appliances
- Periodontal splinting or crown and bridgework in conjunction with periodontal splinting
- Restorations necessary to correct vertical dimension or to modify shape of teeth or occlusion
- Ridge extension for insertion of dentures
- Tooth transplants.

Major Services

- Cleaning of prosthetic appliances
- Crowns or copings in conjunction with overdentures
- Crowns or onlays placed because of weakened cusps or existing large restorations without overt disease
- Crowns used as an abutment to a partial denture for recontouring, repositioning or increasing retention (unless the tooth is decayed to the extent a crown would be needed whether or not a partial denture is required)
- Crowns used to repair micro-fractures of tooth when it displays no symptoms or existing restorations with defective margins when no disease exists
- Duplicate dentures
- Personalized dentures
- Surgical placement or removal of implants or attachments to implants.

SPECIAL SITUATIONS

If You Need Emergency Care

Emergency is defined on page 24.

If you need emergency care, you may see either a participating or non-participating dentist. Your benefits depend on the type of services you receive; see "Dental Plan Summary" on page 5 and "Incentive Plan" on page 6 for benefit levels.

If You Need Care While Traveling

If you receive treatment from a dentist outside Washington state, you pay the dentist in full, then submit a claim form as described in "Filing a Claim" on page 15. Payment will be based on the dentist's charge or the amount that would have been payable if treatment had been provided by a participating WDS dentist, whichever is less.

If Your Family Member Lives Away From Home

Family members who live away from home either temporarily or permanently may see a non-participating dentist and still receive benefits from this plan. Your family member must file a claim as described on page 15.

If You Take a Leave of Absence

You must contact Employee Benefits and Well-Being to arrange to continue your dental coverage during a leave of absence. Your coverage will continue (at the cost you currently pay) for the periods established by your collective bargaining agreement.

If You Leave Employment to Perform Military Service

If you leave employment to perform uniformed service (such as service in the military), you may continue dental coverage for up to the shorter of 18 months or the period of your service under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Generally, you must pay the full cost of coverage. To be eligible, you must meet the requirements under USERRA. Contact

Employee Benefits and Well-Being for more information. The Veterans Employment and Training Administration is also required to assist you.

If You Leave Employment to Perform Military Service (cont'd)

If you don't arrange to continue coverage, it will end on the last day of the month you leave employment.

You must give Employee Benefits and Well-Being written notice when you leave employment covered by these plans to perform military service. You must also give Employee Benefits and Well-Being written notice when you return after your military service to employment covered by these plans.

If You Enter Into a Labor Dispute

If your pay is suspended directly or indirectly as a result of strike, lockout or other labor dispute, you may continue dental coverage for up to 6 months for yourself and your eligible family members if you pay the full cost of dental coverage directly to Employee Benefits and Well-Being. At the end of 6 months, you may be eligible for up to 12 more months of coverage under COBRA; see page 20 for details.

If You Are Laid Off

If you are laid off while a participant in this plan, dental coverage for you and your eligible family members may continue for a limited time by paying the full cost of coverage. See "Continuation of Coverage (COBRA)" on page 20.

Contact Employee Benefits and Well-Being for more information.

If you return to work as an eligible employee within 24 months of the date you were laid off, coverage begins the first of the month following your return. If you return after 24 months, you will be considered a newly hired employee.

If You Die

If you die while a participant in this plan, dental coverage for your eligible family members may continue for a limited time if they pay the full cost of coverage. See page 20.

If You Become Disabled

If you or covered family members participating in this plan are totally disabled and your coverage ends for any reason except plan termination, coverage may be extended for 6 months at no cost to you.

Extension coverage will end on the date coverage is discontinued for the group you belonged to just before you become disabled or on the date you or your family members:

- Reach any lifetime maximum that may apply
- Are no longer disabled
- Become eligible for benefits under another group policy or
- Reach the end of the 6-month extension.

When you reach the end of this 6-month extension you may elect COBRA coverage as described on page 20.

If You Retire

Retirees are not eligible for the dental coverage described in this booklet.

FILING A CLAIM

You may obtain claim forms from Employee Benefits and Well-Being or WDS. WDS pays benefits only if claim forms are submitted within 6 months from the date of treatment.

If you visit a participating dentist, the dentist will submit claim forms for you. If you see a non-participating dentist, you pay the dentist in full — and it's your responsibility to submit a claim form (or have the dentist submit it for you). Benefit payments are based on UCR fees (see "Definition" on page 26 for details).

If you want to receive the payment directly, you must attach your receipt to the claim form when you file a claim. Send claims to:

Washington Dental Service
PO Box 75688
Seattle WA 98125-0688
(800) 554-1907

APPEALING A CLAIM

If your claim is denied in whole or in part, you will be notified in writing of the reason for the denial within 90 days from the date you filed your claim. The notice will include information required if you want to appeal.

You may appeal a denied claim within 60 days of the date you receive the denial notice. This procedure is the only means available to change a benefit decision. To appeal, write to the plan and state the reasons you believe your claim should have been paid. Include any additional documentation to support your claim. You also may submit questions or comments you think are appropriate and you may review relevant documents.

Normally, you will receive a written decision on your appeal within 60 days of the date the plan receives your request. If special circumstances require a delay, you will be notified of the extension during the 60 days after receipt of your request.

If you have an appeal regarding the denial of benefits for investigational or experimental services, the plan will provide a written explanation within 20 working days of receiving the request for an appeal (unless the plan determines a 20-day extension is warranted due to extenuating circumstances regarding the review process).

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

In accordance with applicable law, the plan provides dental coverage to certain children of yours (called “alternate recipients”) if directed by certain court or administrative orders. This is a decree, judgment or order from a state court (including approval of a settlement agreement) or administrative order that requires the plan to include a child in your coverage and make any applicable payroll deductions.

A medical child support order is generally considered qualified and enforceable if it specifies:

- Employee name and last known address
- Each alternate recipient's name and address
- A description of the coverage the alternate recipient will receive
- The coverage effective date
- How long the child is entitled to coverage
- Each plan subject to the order.

When the county receives a medical child support order, we promptly notify you and the alternate recipient that the order has been received and what procedures will be used to determine if the order is qualified. Once the decision is made, we will notify you and alternate recipient(s) by mail.

COORDINATION OF BENEFITS

In no case will you receive more than 100% of the covered expense.

If you or your family members have additional dental coverage, benefits from the other plan(s) may be considered before benefits are paid under this plan. Additional coverage includes another employer's group benefit plan or other group arrangement — whether insured or self-funded.

The plan that must pay benefits first is considered primary and will pay without regard to benefits payable under other plans. When another plan is primary, your King County dental plan will coordinate benefits so you receive maximum coverage (the highest allowable charge).

If you or your family members are covered under another plan which is primary, be sure to keep a copy of your itemized bill and send the bill and Explanation of Benefits to Washington Dental Service.

If the other plan does not have a coordination of benefits provision, that plan will pay first. If it does, the following rules determine payment:

- The plan covering an individual as an employee will pay first.

- The plan of the parent whose birthday is first in the calendar year pays for covered children first unless the parents are divorced or legally separated. (If the other plan does not have this rule, the other plan's provisions will apply.)

COORDINATION OF BENEFITS (cont'd)

- If the parents are divorced or legally separated, these rules apply:
  - If the parent with custody (or primary residential placement) has not remarried, the plan of that parent pays before the plan of the parent without custody
  - If the parent with custody has remarried, the plan that covers the child is determined in this order: plan of the parent with custody, plan of the spouse of the parent with custody, plan of the parent without custody, plan of the spouse of the parent without custody
  - If the court decree establishes financial responsibility for the child's health care, the plan of the parent with that responsibility will pay first.

If these provisions don't apply, the plan that has covered the employee longer pays first. Nevertheless, if either parent is retired, laid off or a family member of a retired or laid-off person, the plan of the person actively employed will pay first (unless the other plan doesn't have a provision regarding retired or laid-off employees).

The plan has the right to obtain and release data as needed to administer these coordination procedures. For example, if your plan paid too much under the coordination of benefits provision, it has the right to recover the overpayment from you or your provider.

WHEN COVERAGE ENDS

Employees

Your dental coverage ends on the last day of the month in which you:

- Are no longer eligible as defined on page 1
- Resign, retire or are terminated.

Your dental coverage also ends on the day:

- The plan terminates
- You die.

Family Members

Your family members' dental coverage ends on the last day of the month in which your:

- Coverage ends
- Family member is no longer eligible as defined on page 1.

Your family members' dental coverage also ends on the day:

- The plan terminates
- Your family member dies.

CERTIFICATE OF COVERAGE

When your coverage under this plan ends, you will automatically receive a certificate of health plan coverage. This is an important document and should be kept in a safe place. You may take this certificate to another health plan to receive credit against a preexisting condition limit for the time you were covered under this plan. You will need to do this only if the other health plan has a preexisting condition limit.

CONTINUATION OF COVERAGE (COBRA)

To continue coverage, you or your family members must elect COBRA coverage and pay the required premium before the payment deadline.

Continued dental coverage may be available to you and your covered family members under COBRA if coverage ends because of a qualifying event (described below).

Eligibility

You and your covered family members are eligible for up to 18 months of COBRA coverage if you lose coverage because your:

- Employment ends for reasons other than gross misconduct or
- Work hours are reduced to the point where you no longer are eligible for benefits.

If you or your family member who is a qualified beneficiary is determined to be Social Security disabled at the time of one of the above qualifying events (or at any time within the first 60 days of continuation coverage), you and your family members are eligible for up to a total of 29 months of COBRA coverage. Employee Benefits and Well-Being must receive a copy of your Social Security Disability approval letter before the end of the first 18-month continuation period and within 60 days after the date of the Social Security Administration determination.

If a second qualifying event occurs during a continuation period, your family members may continue coverage up to a total of 36 months from the first qualifying event.

Covered family members who are qualified beneficiaries are eligible to continue coverage up to a total of 36 months if coverage ends because of any of these qualifying events:

- Your death
- Your divorce or legal separation
- The loss of dependent-child status
- Your entitlement to Medicare.

How to Apply

If you gain a family member while participating in COBRA, the usual plan rules for enrolling family members will apply. See "Enrolling in the Plan" on page 3 for details.

If you and/or your family member(s) lose dental coverage as a result of termination or reduction of hours, your death or Medicare entitlement, Employee Benefits and Well-Being will notify you and/or your family member(s) of your options. If your family member will lose coverage because of divorce, legal separation or a child losing eligibility, you or your family member must notify Employee Benefits and Well-Being within 60 days of the qualifying event or the date coverage ends, if later. Otherwise, your family member's right to continue coverage under COBRA ends.

When your current coverage is scheduled to end, you and your family members will receive details about COBRA. To continue coverage, you must elect COBRA within 60 days after the later of loss of coverage because of a qualifying event or the date of your notice of eligibility to continue coverage.

Paying for COBRA Coverage

Employee Benefits and Well-Being will give you payment amounts and deadlines.

You or your covered family members must make the initial payment within 45 days of the date you elect to continue coverage. Because COBRA coverage is retroactive to the day coverage ended, your initial payment must include all applicable back premiums.

You must keep paying the cost of COBRA coverage on time or it automatically ends.

When COBRA Coverage Ends

COBRA coverage ends when you or your family members:

- First become covered under another group health plan after the date of your COBRA election, unless that plan limits or excludes coverage for a preexisting condition of the individual continuing coverage
- Fail to make the required payments within 30 days of the due date

COBRA coverage also ends if King County terminates the plan and no longer provides dental benefits to active employees.

- First become entitled to Medicare benefits after the date of your COBRA election
- Reach the end of the maximum COBRA coverage period or
- Are no longer disabled as determined by the Social Security Administration.

ASSIGNMENT OF BENEFITS

Plan benefits are available to you and your covered family members only. The right to payment under this plan is not subject to attachment or garnishment and the plan will not honor any assignment of benefits to anyone.

In paying for services, the plan may make the payment to you, the provider or another carrier. The plan will also make payments on behalf of an enrolled child to his or her non-enrolled parent or a state Medicaid agency when required to do so by federal or state law. In these cases, the plan also has the right to make payment jointly.

All payments are subject to applicable federal and state law and regulation. Payments made according to this section will discharge the plan to the extent of the amount paid, so that the plan will not be liable to anyone aggrieved by the choice of payee.

THIRD PARTY CLAIMS

If you receive benefits for any condition or injury for which a third party is liable, the plan may have the right to recover the money paid for benefits. This means the plan is not obligated to pay for services necessary because of an injury or condition for which you may have other recovery rights unless or until you (or someone legally qualified and authorized to act for you) promise in writing to:

- Include those amounts in any claim you or your representative makes for the injury or condition

- Repay the plan those amounts to the extent the proceeds of your recovery for the injury or condition exceed the total loss, prorating any attorneys' fees incurred in the recovery

- Cooperate fully with the plan in asserting plan rights — supplying any and all information and executing any and all documents reasonably needed for that purpose.

Any sums collected by or on behalf of you or your covered family members by legal action, settlement or otherwise — on account of benefits provided under this plan — are payable to the plan only after and to the extent the sums exceed the amount required to fully compensate you for your loss.

RECOVERY OF OVERPAYMENTS

The plan has the right to recover amounts paid that exceed the amount for which the plan is liable. This amount may be recovered from 1 or more of the following (to be determined by the plan): any persons to or for or with respect to whom such payments were made, any other insurers, any service plans or any organizations or other plans. These amounts may be deducted from your future benefits (or your family members' benefits, even if the original payment was not made on that family member's behalf).

The plan's right of recovery includes benefits paid in error due to any false or misleading statements made by you or your family members.

PAYMENT OF BENEFITS

The dental benefits are funded by the county (this is a self-funded plan). This means the county is financially responsible for claim payments and other plan costs.

TERMINATION AND AMENDMENT OF THE PLAN

The county fully intends to continue plan benefits indefinitely, but also reserves the absolute right to amend or terminate the plan for any reason at any time. If the county terminates the plan, bona fide claims incurred before termination will be paid.

DEFINITIONS

To help you better understand your dental benefits, here's a list of important definitions.

Accidental Bodily Injury	An unexpected external force (for example, car accident or fall) that results in an injury to your mouth.
Alveolar	The ridge, crest or bone that projects from the upper and lower jaw and supports the roots of the teeth.
Apicoectomy (root tip amputation)	The excision of the apical portion of a root to gain access to the periapical area to remove diseased tissue.
Bitewing X-ray	An x-ray that reveals the condition of the top visible part of the upper and lower molar teeth.
Coinsurance	The amount you share with the plan toward covered expenses.
Crown	The portion of the tooth covered by enamel.
Emergency Exam	An exam of any condition that demands the immediate attention of a dentist.
Fluoride	A substance that when topically applied or added to drinking water is effective in resisting tooth decay.
General Anesthesia	A drug or gas that produces unconsciousness and insensibility to pain.
Gingival Curettage	The process of removing or cutting diseased soft tissue surrounding the tooth.
Iliac Crest	Top of the hip bone used for grafting bone onto the lower jaw.

Implant	A graft or insert set firmly onto or deeply into the alveolar area prepared for its insertion. It may support a crown or crowns, a bridge abutment, a partial denture or a complete denture.
Inlay	A dental filling shaped to the form of a cavity and then inserted and secured with cement.
Intravenous Sedation	A form of sedation where the patient experiences a lowered level of consciousness but is still awake and can respond.
Limitations	Restricting conditions, such as age, period covered and waiting periods.
Nightguard	An appliance used to treat the unconscious habit of gnashing or grinding of the teeth while sleeping or at times of stress.
Occlusion	The contact of the teeth of both jaws when closed or during the movements of the mandible in mastication (chewing).
Occlusal Adjustment	Modification of the occluding surfaces of opposing teeth to develop harmonious relationships between the teeth and neuromuscular mechanism, the temporomandibular joints and the structure supporting the teeth.
Onlay	A restoration of the entire contact surface of the tooth.
Orthodontic Treatment	The necessary procedures of treatment, performed by a licensed dentist, involving surgical or appliance therapy for movement of teeth and post-treatment retention.
Orthognathic Surgery	Procedure to correct malpositions of the upper jawbone (maxilla) and/or the lower jaw bone (mandible).
Overdenture	A removable denture constructed over existing natural teeth or implanted studs.
Panorex X-ray	An x-ray system using 2 points of rotation to obtain a panoramic view of the dental arches.
Plaque	Flat masses of bacteria and debris on tooth surfaces.
Prophylaxis	The control of dental and oral diseases by preventive measures, especially the mechanical cleansing of the teeth.

Prosthodontics	The branch of dentistry that deals with the replacement of missing teeth or oral tissues by artificial means, such as crowns, bridges and dentures.
Pulp Exposure Treatment (pulp capping)	The covering of an exposed dental pulp with a material that protects it from external influences and does not interfere with pulpal healing. It stimulates the formation of secondary dentin in an effort to maintain the health and vitality of the pulp of the tooth.
Pulpotomy	An operation by which the bulbous or crown portion of the dental pulp is removed.

DEFINITIONS (cont'd)

Rebase	A process of refitting a denture by replacing the denture base material without changing the occlusal relations of the teeth.
Reline	To resurface the tissue side of a denture with a new base material so it will fit more accurately.
Restorative	A process used to replace a lost tooth or part or the diseased portion of a tooth by artificial means as with a filling, crown, bridge or denture designed to restore proper dental function.
Root Planing	A procedure done to smooth roughened root surfaces.
Sealants	A resinous material designed for application to the surfaces of posterior teeth to seal surface irregularities and prevent tooth decay.
Specialist	A licensed dentist who has successfully completed an educational program accredited by the Commission of Dental Accreditation, 2 or more years in length, as specified by the Council on Dental Education or be diplomats of an American Dental Association recognized certifying board.
Temporomandibular Joint (TMJ)	The joint just ahead of the ear, upon which the lower jaw swings open and shut and can also slide forward.
Usual, Customary and Reasonable (UCR) Fees	The fees typically charged for comparable dental services provided by health care professionals in a given region with similar training and experience.

PARTICIPANT BILL OF RIGHTS

If you have questions about your benefits, contact the plan as shown in the Directory.

As a plan participant, you have certain rights, as described below.

Dignity and Respect

You have the right to be treated with consideration, dignity and respect. You also have the responsibility to respect the rights, property and environment of all providers and other patients.

You have the right to see your own medical records and to have those records kept private and confidential unless required to settle a claim.

You have these rights regardless of your gender, race, sexual orientation, marital status, culture or economic, educational or religious background.

Knowledge and Information

You also have the right to take an active part in decisions about your care. Once you participate in and agree to a treatment plan, you are responsible for following that plan or telling your dentist otherwise.

You have the right — and the responsibility — to know about and understand your health care and your coverage, including:

- Names and titles of all providers involved in your care
- Medical condition and health status
- Services and procedures involved in your treatment plan
- Ongoing health care you need once you're discharged or leave the dentist's office
- How the plan works (you will find that information in this booklet)
- Medication prescribed for you — what it is, what it's for, how to take it properly and possible side effects.

Continuous Improvement

You are partners with your plan, your dentist and other health care professionals involved in your care.

You have the right to:

- Call or write with any questions or concerns and make suggestions for improving the plan
- Ask your dentist to explain or give you more information about any advice or prescribed treatment
- Appeal any dental or administrative decisions (see "Appealing a Claim" on page 16).

Plan Participant Accountability and Autonomy

As a partner in your own health care, you have the right to:

- Refuse treatment — as long as you accept responsibility and the consequences of that decision
- Complete an advance directive, such as a living will or durable power of attorney, for health care
- Refuse to take part in any medical research projects
- Be advised on the full range of treatment options (whether covered under this plan or not) and their potential risks, benefits and costs
- Make the final choice among treatment alternatives.

You also are responsible to:

- Show your identification card to your dentist, hospital or other provider before you receive care
- Provide your dentist with all previous dental records and give accurate, complete dental information to all dentists or other providers involved in your care
- Be on time for appointments and let your dentist's office know as far in advance as you can if you need to cancel or reschedule
- Follow instructions given by those providing your care

If you decide to give someone else the legal power to make decisions about your health care, that person will also have all of these rights and responsibilities.

- Send copies of claim statements or other documents if requested
- Let your plan know within 24 hours or as soon as reasonably possible if you receive emergency care or out-of-area urgent care
- Tell your plan and your dentist about planned health care, such as a surgery or an inpatient stay.